Clinic/Animal Hospital: ____

Requesting Doctor: ____

Phone: ____________________ Fax Phone: ________________________________

Physical Address: ____

____

Last Name: ___________________________ Owner First Name: ____________________

Pet Name: ____________________________ Patient ID: _________________________

Species: ______________________________ Breed: ____________________________

Age: _____________ Weight: _____________ Sex: M MN F FS Unknown *(circle one)*

Exam Type: ________________________ *Exam Date:* _______________________

Number of X-rays submitted: ___________________

Patient was anesthetized during x-ray acquisition: Y N ***(circle one)***

Views *(please check/circle all that apply)*:

- ☐ Skull
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Thorax
- ☐ Abdomen
- ☐ Pelvis
- ☐ Sinus
- ☐ Shoulder (R or L)
- ☐ Humerus (R or L)
- ☐ Elbow (R or L)
- ☐ Antebrachium (R or L)
- ☐ Carpus (R or L)
- ☐ Forepaw (R or L)
- ☐ Hip (R or L)
- ☐ Femur (R or L)
- ☐ Stifle (R or L)
- ☐ Tibia/Fibula (R or L)
- ☐ Tarsus (R or L)
- ☐ Hindpaw (R or L)
- ☐ Soft Tissue Neck
- ☐ Fetlock (R or L)
- ☐ Distal Extremity
- ☐ Other Exam: ________

Relevant Health History/Notes: ____

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Attach additional pages for notes as needed.

Mail Requests To:

PetRays Veterinary Telemedicine Consultants
2024 Rayford Road, Spring, TX 77386
888-473-8729 or 713-395-7900